11. COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN (CAP/C)

This section describes Medicaid's coverage of services provided for CAP/C participants. It tells you about:

- What CAP/C Covers – See 11.1, page 11-2
- Who's Covered – See 11.2, page 11-3
- Limitations – See 11.3, page 11-3
- Who May Provide CAP/C Services – See 11.4, page 11-4
- Getting a Service – See 11.5, page 11-5
- Coordinating Care – See 11.6, page 11-6
- Delivering and Supervising Care – See 11.7, page 11-6
- Changing Services – See 11.8, page 11-6
- Changing Provider Agencies – See 11.9, page 11-6
- Terminations – See 11.10, page 11-6
- CAP/C Records – See 11.11, page 11-6
- Getting Paid – See 11.12, page 11-7

The material in this section is primarily directed to providers other than the CAP/C case management agency. Information specific to the case management agencies and the services which they provide is in the *CAP/C Manual*.

At the end of this section are some of the questions often asked about CAP/C and answers to those questions. See CAP/C Q&A (page 11-10). A description of CAP is in Section 2.

Participants in CAP/C are referred to as "clients" throughout this section.

11.1 What CAP/C Covers

The services covered under CAP/C include:

11.1.1 Case Management

Case management includes assessing the client for CAP/C participation, planning care and locating, obtaining, coordinating, and monitoring social and medical services as well as other services related to the purpose of the program. The case manager's responsibilities are in the *CAP/C Manual.*

11.1.2 CAP/C Nursing Services

CAP/C Nursing Services are continuous, complex and substantial nursing care ordered by the physician. Nursing care to monitor for potential complications is not covered. The service may include performance of specialized procedures, preparation of equipment and material for treatment, assistance in learning appropriate self-care techniques, and other medical tasks performed on an ongoing, daily basis. The nurse may also assist the child with eating or feeding, transfers, ambulation, and other personal care tasks when needed as an integral part of the child's day-to-day treatment plan. In addition to providing care in the home, the nurse may accompany a child outside of the home when the child's normal life activities (such as attending school during the day) take the child away from the home during the day. If the care is to be provided in another private residence, such as another relative's home, the setting must be assessed and approved by the case manager prior to the delivery of the service.

11.1.3 CAP/C Personal Care Services

CAP/C Personal Care Services is assistance for children who need help with personal hygiene, ambulation, and feeding due to a medical condition. The service also includes help with home management tasks that are essential, although secondary, to the personal care tasks that are necessary for maintaining the child's health. This service includes the same tasks as those included in regular Medicaid Personal Care Services as described in 6.1. In addition to performing these tasks, the CAP/C Personal Care aide may also function in a supportive role by accompanying the client outside the home and facilitating participation in activities of daily living.

REMEMBER: *CAP/C is not meant to replace services covered by other reimbursement sources. For example, CAP/C Personal Care services may not be provided to a child at school during school hours. It also may not be provided in a day care center as the center is being paid for the care of the child.*

11.1.4 CAP/C Waiver Supplies

Waiver Supplies include:

- Reusable incontinence undergarments with disposable liners for children age two and above.
- Nutritional supplements prescribed by a physician that are taken by mouth (such as "Enrich", "Ensure" and similar supplements covered by Medicaid for tube feedings).

11.1.5 Home Mobility Aids

Home mobility aids are the following items provided to give mobility, safety and independence to the client in his private residence. They are used to adapt the home environment to the client's specific disabilities.

- Wheelchair Ramps
- Safety Rails

- Grab Bars
- Handheld Showers
- Widening of Doorways for Wheelchair Access
- Non-skid Surfaces (rough surfaced strips of adhesive material that adhere to non-carpeted areas such as concrete, linoleum, wood, tile, porcelain, or fiberglass)

11.1.6 Respite Care

Respite care provides temporary support to a family caring for a CAP/C child. It may be used as day, evening or overnight care to meet a range of client needs. These include family emergencies; planned absences, such as vacations, hospitalizations or business trips; relief from the stresses of caregiving; shopping and giving a child respite from his family. Respite care is available as **In-Home Respite** in which the respite worker goes into the client's home, and as **Institutional Respite** in which the client goes into a facility licensed to provide the appropriate level of care.

11.2 Who's Covered

Whether a client is covered for a CAP/C service depends on three factors:

11.2.1 The Type of Medicaid Coverage

A client must be covered under regular Medicaid coverage – that is, have a **BLUE** card.

11.2.2 Approval of CAP/C Participation

A client's CAP/C participation must be approved according to CAP/C procedures. A CAP/C client has an **IC, SC** or **HC** in the CAP block of the Medicaid ID card.

11.2.3 Approval of the Service in the Plan of Care

Each CAP/C service, including its amount, duration and frequency, must be approved in the client's CAP/C Plan of Care.

11.3 Limitations

11.3.1 Prior Approval

Prior approval in the CAP/C Plan of care is required for each CAP/C service provided to a client.

11.3.2 Amount of Service

The amount of service is limited to that which is approved in the CAP/C POC. The individual service limits that are considered in approving the plan include:

- **Home Mobility Aids:** The cost of aids is limited to $1,500 for a state fiscal year (July-June).
- **Respite Care:** The amount of respite care may not exceed 30 days (720 hours) in a state fiscal year (July-June).

11.3.3 Other Limitations

Medicaid payment is restricted in relation to the following services:

- **CAP/C Services:** You may not bill for a CAP/C service while a client is in an institution such as a hospital, nursing facility or ICF/MR. CAP/C case management agencies should refer to the *CAP/C Manual* for an exception for certain case management activities.

- **CAP/C Personal Care Services:** You may not bill for this service if it is provided on the same day that the client receives a substantially equivalent service such as regular Medicaid PCS or a home health aide visit.

11.4 Who May Provide CAP/C Services

You may provide the CAP/C services approved in your Medicaid participation agreement by DMA. See Section 18 for information on provider enrollment. Each service's qualifications follow.

NOTE: *CAP/C case management agencies may provide medical supplies – the items on the Home Health supply list – to CAP/C clients.*

11.4.1 Case Management

Case managers are designated from the local agency that is most appropriate to meet the child's needs. DMA coordinates the selection of the agency and the case manager. The selection is based on familiarity of the case needs, knowledge of community resources and ability to participate. The case manager's qualifications are in the *CAP/C Manual.*

11.4.2 CAP/C Nursing Services

Your agency must be a home care agency licensed by the Division of Facility Services to provide nursing services. The nurses providing care must be licensed in North Carolina and qualified to provide the care needed by the client.

NOTE: *You may not employ a client's parent, spouse, grandparent or sibling as the nurse for the client. This includes any person with an equivalent step or in-law relationship to the patient.*

11.4.3 CAP/C Personal Care Services

Your agency must be a home care agency licensed by the Division of Facility Services to provide in-home aide services. Supervisors and aides must meet the same qualifications as those for regular Medicaid PCS. See 6.4.

NOTE: *You may not employ a client's parent, spouse, grandparent or sibling as the aide for the client. This includes any person with an equivalent step or in-law relationship to the patient.*

11.4.4 CAP/C Waiver Supplies

This service is provided through the CAP/C case management agency. Requirements for the service are in the *CAP/C Manual.*

11.4.5 Home Mobility Aids

This service is provided through the CAP/C case management agency. Requirements for the service are in the *CAP/C Manual.*

11.4.6 Respite Care:

The qualifications depend on the type of respite.

- **In-Home Respite:** Your agency must be a home care agency licensed to provide In-Home Aide services by the Division of Facility Services. The aide must be qualified and supervised according to the Home Care Licensure Rules. An aide performing any Level III-Personal Care

task or any task deemed by the North Carolina Board of Nursing as requiring a Nurse Aide I must be registered with the Division of Facility Services as a Nurse Aide I.

- **Institutional Respite:** This service is provided in a facility licensed to provide the level of care required by the client. For example, a client who requires skilled nursing facility care must be placed in a facility licensed to provide that level of care.

11.5 Getting a Service

After DMA approves a child for CAP/C, the CAP/C case manager arranges for the CAP/C services approved in the CAP/C Plan of Care. The following outlines the basic steps to get a CAP/C service from your agency. The steps are in the order that they are usually accomplished.

CAUTION: *CAP/C case managers may authorize only CAP/C services – they have no authority to order or approve other Medicaid services.*

Step 1 Receive Service Authorization

The CAP/C case manager sends you a written authorization that includes:

- The client's name (as it appears on the Medicaid card), Medicaid ID number, address and phone number.
- The name, address and phone number of the client's parent(s)/guardian.
- The name and phone number of the client's case manager.
- The type of services to be provided, when they are to be provided, where they are to be provided and their expected duration.
- The amount to be paid for the services. You bill your usual and customary charges for CAP/C personal care services, CAP/C nursing services and respite care. If your usual charge for these services is in excess of the Medicaid maximum allowable, your usual charge should be shown in the authorization as well as the amount that Medicaid will pay.

Step 2 Verify Medicaid Eligibility

Check to see that the client has a **BLUE** Medicaid ID card with an **IC**, **SC** or **HC** in the CAP block in the upper left corner of the card. Contact the CAP/C case manager if the card is not blue or one of the above CAP/C codes is not in the CAP block. See Section 3 for a sample Medicaid ID card.

REMEMBER: *Check all the key information on the card – such as eligibility dates, insurance information, and other important items noted in Section 3.*

Step 3 Consider Appropriateness

The case manager's orders are based on a thorough assessment of the client's needs. You do not have to repeat that process; however, review the information about the client and the client's situation to ensure that the service appears appropriate and that you can provide the ordered service.

Step 4 Resolve Questions

If you have incomplete information or your review raises questions, contact the CAP/C case manager about your concerns before proceeding.

11.6 Coordinating Care

The CAP/C case manager is primarily responsible for coordinating services. You need to ensure the best care for the client while avoiding duplication or overlap. When you observe potential problems or conflicts, contact the CAP/C case manager.

11.7 Delivering and Supervising Care

Provide the service as ordered by the CAP/C case manager. Be sure that it is provided and supervised according to all applicable laws, regulations and professional practices.

11.8 Changing Services

Contact the client's CAP/C case manager when a service needs to be changed.

- **Rescheduling a Service:** Follow the procedures given to you by the CAP/C case manager when a service must be rescheduled. You may not change the schedule without the approval of the case manager.

- **Changing the Amount, Duration or Frequency of a Service:** When you believe that a change is needed in how much of a service is provided, how long it is provided or how often it is provided, contact the CAP/C case manager. The case manager has to follow CAP/C policies and procedures regarding changes in services.

11.9 Changing Provider Agencies

A change of providers may occur due to the client exercising his freedom of choice of providers, the inability of the provider to continue care or for other reasons. Contact the CAP/C case manager to initiate a change.

11.10 Terminations

The CAP/C case manager coordinates the termination of a CAP/C service as well as the client's participation in the program. The case manager will notify you in writing if a service is to be stopped. If you need to stop a service, contact the case manager.

11.11 CAP/C Records

The following provides instructions specific to CAP/C. These are in addition to the record keeping responsibilities for all Medicaid providers in Section 4. You must document the provision of a service before seeking Medicaid payment. Your records must provide an audit trail for services billed to Medicaid.

Documentation requirements differ according to the service. You must also keep related personnel, financial and other management records as required by the Medicaid Provider Participation Agreement, Medicaid rules, and State and Federal Law.

REMEMBER: *This section includes Medicaid's minimum requirements for client records and related information. Nothing in this section relieves a provider from the rules and requirements of other entities.*

All records must contain the client's name and MID as on the Medicaid ID card. Keep:

- Service authorizations from the CAP/C case manager, including any amendments to those authorizations, and related correspondence.

- Copies of claims submitted to Medicaid and third party payers, as well as related correspondence.
- Service documentation that shows:
  - What service was provided;
  - The date that the service was provided;
  - Where the service was provided; and
  - The following information specific to the service:

    CAP/C Nursing Services: Nursing notes that fully document the provision of the service and the care and treatment provided to the client. The notes must establish when the care was provided, document all nursing interventions (time, activity and results), and substantiate that care was provided according to the physician's orders and CAP/C service authorization. In addition to providing documentation for billing, nursing notes are periodically reviewed by the case manager and the HCI staff to determine the continuing need for CAP/C Nursing Services as well as assisting in level of care determinations.

    CAP/C Personal Care Services: Time logs kept in either weekly or daily formats maintained by each aide that provides services. After providing the service, the aide enters the date of service, the time the service begins, the time it ends and the tasks performed. The aide signs and dates the log to certify that he worked the time and dates listed, and performed the indicated tasks. The client/responsible party must sign the log to certify that the tasks were performed satisfactorily and that the time is correct. See Illustration 6-5 in Section 6 for a sample log.

    Respite: The dates and times that the care was provided, where it was provided and the name of the person who provided it.

The case management agency also keeps the records noted in the *CAP/C Manual*.

11.12 Getting Paid

The instructions for filing claims are in Section 14. Keep the following in mind for CAP/C claims.

NOTE: *CAP/C case management agencies refer to the CAP/C Manual for billing instructions for their services.*

11.12.1 What May Be Billed

You may bill Medicaid for the following services up to the amount ordered by the CAP/C case manager, approved on the client's CAP/C Plan of Care, and provided according to Medicaid policies and procedures.

CAUTION*: Medicaid is responsible for paying for a service as it is approved on the CAP/C Plan of Care. If a CAP/C case manager orders something that was not approved on the plan, payment is resolved between the local agency providing CAP/C case management and the provider agency.*

- **CAP/C Nursing Services:** Bill for the number of 15-minute units per day provided to the client.
- **CAP/C Personal Care Services:** Bill for the number of 15-minute units per day provided to the client.

- **Respite Care - Institutional:** Bill the calendar days that your facility provided respite care to the client.

- **Respite Care - In-Home:** Bill for the number of 15-minute units per day provided to the client.

For services that use 15 minutes as the unit of service, you may round to the nearest 15 minutes to determine how many units that you may bill. Though a full 15 minutes of service is expected to be provided for each unit billed, at times it will not be possible to complete a service exactly in a 15 minute period. At those times, you convert time to units as follows:

Step 1 Total the amount of time spent providing the service during the day;

Step 2 Divide the total by 15 to get the number of full units; and

Step 3 Add an additional unit if the remainder is 8 minutes or more.

REMEMBER: *You may not bill for time spent traveling to and from the client. This is considered to be part of the overhead cost included in your rate.*

11.12.2 Unit of Service

CAP/C Nursing Services: The unit is **15 MINUTES**.

CAP/C Personal Care Services: The unit is **15 MINUTES**.

Respite Care - Institutional: The unit is a **DAY**.

Respite Care - In-Home: The unit is **15 MINUTES**.

11.12.3 Payment Rate

The maximum rates are included in the Medicaid fee schedule for CAP/C.

- **CAP/C Nursing Services, CAP/C Personal Care Services, and Respite Care - In-Home**: Your payment is calculated based on the lower of your billed usual and customary charge, and the maximum allowable rate.

- **Respite Care - Institutional:** Your payment is calculated based on the least of your charge, your Medicaid rate and the maximum allowable rate.

11.12.4 Claim Preparation

Prepare your claim on a HCFA-1500. See 14.7 for general instructions for the form.

Use the following guidance for completing item 24 on the form – the part that provides the details about what you are billing. Item 24 has several lines for listing the billed services. Each line is often referred to as a "detail."

24A. DATE(S) OF SERVICE, FROM/TO: Your entry depends upon the service.

CAP/C Nursing Services: Use a separate line for each day that the service is provided. Place the date of service in the FROM block. Enter the same date in the TO block.

CAP/C Personal Care Services: Use a separate line for each day that the service is provided. Place the date of service in the FROM block. Enter the same date in the TO block.

Respite Care - Institutional: Combine all consecutive days of service on one line. The FROM entry is the first date of service and the TO entry is the last consecutive date of service. If the service is provided for only one day, list it on a separate line. Remember that when consecutive days are billed on a line, the units shown in **24G** must equal the number of days in **24A**.

Respite Care - In-Home: Use a separate line for each day that the service is provided. Place the date of service in the FROM block. Enter the same date in the TO block.

24B. Place of Service: Enter **12**.

24C. Type of Service: Enter **01**.

24D. PROCEDURES, SERVICES OR SUPPLIES: Enter the appropriate HCPCS code. Do not enter any information under **MODIFIER**.

CAP/C Nursing Services: **W8139**

CAP/C Personal Care Services: **W8143**

Respite Care - Institutional: **W8154**

Respite Care - In-Home: **W8145**

24E. DIAGNOSIS CODE: Leave blank.

24F. CHARGES: Enter total charge for the service on the line. The charges are your unit rate times the number of units billed on the line.

24G. DAYS OR UNITS: Enter the number of 15-minute units or days as appropriate.

24H. EPSDT/Family Planning: Leave blank

24I. EMG: Leave blank.

24J. COB: Optional.

24K. RESERVED FOR LOCAL USE: Either enter the name of the service or leave blank.

11.12.5 Claim Submission

Send the paper claim or a printout of the electronic claim to the CAP/C case manager for approval before sending it to EDS. The case manager will review the claim to see if it accurately reflects services approved in the CAP/C Plan of Care.

CAUTION: **DO NOT SEND** *a paper or electronic claim to EDS before the case manager approves the claim. Claims submitted and paid before the case manager's approval are subject to recoupment.*

- **Accurate Claims:** The case manager approves a paper claim by signing the bottom of the claim form and forwarding the claim to EDS. The case manager approves an electronic claim by signing the bottom of the printout and returning the printout to your agency.

- **Inaccurate Claims:** The case manager contacts your agency to resolve the discrepancy.

CAP/C Q & A

The following includes some of the common questions about CAP/C and the answers to those questions.

1. **Q.** The mother of a CAP/C client has brought me a note from the child's physician to increase the number of hours per day of Hourly Nursing. May I increase the hours?

A. Do not increase the hours before getting the case manager's authorization to do so. Ask the mother to please contact the case manager to inquire about a change in care. The change will have to be approved by DMA.

2. **Q.** The CAP/C client that we are serving will soon be 19. I understand that she will no longer be eligible for CAP/C when she turns 19. When will her eligibility end and how will she continue to get needed care?

A. The client's CAP/C eligibility will end on the last day of the month in which she becomes 19 years of age. Her case manager will help her look at other options for care, including CAP/DA as well as regular Medicaid services, such as Home Health Services, Private Duty Nursing, and Personal Care Services.

3. **Q.** The client's mother has asked our agency to provide two additional hours of CAP/C Personal Care for just one day so that she can attend a school function for her oldest child. Is it all right to provide the hours?

A. You need the case manager's approval before changing services. Ask the mother to call the case manager to get approval. CAP/C has procedures to make such changes.

4. **Q.** The client's family wants to have its van modified to accommodate the client's wheelchair to make transporting the client easier. Will CAP pay for the modification?

A. No. CAP covers only the services described in 11.1 of this manual. The case manager may be able to assist the family in locating help to pay for the modification.

5. **Q.** A client's mother has asked the PCS Aide employed by our agency to accompany her and the client to a medical appointment. She says that she needs help transporting the client and has no one else to assist. May the aide accompany the client to the medical appointment and bill the time as In-Home Aide Services?

A. No. Tell the mother to talk to the case manager about the problem. The case manager may help the client arrange assistance in transporting the client through the county department of social services or a volunteer.

6. **Q.** One of the clients to whom we provide CAP/C Personal Care Services is terminally ill. We are also a hospice and believe he may benefit from Hospice services. May a CAP/C client also participate in Medicaid Hospice?

A. It depends on whether the client is at ICF, SNF or hospital level of care. A client at ICF or SNF level usually may not receive Medicaid Hospice services because the cost of Hospice causes the client's home care costs to exceed the CAP/C limit. A CAP/C client at hospital level of care may be able to participate concurrently in Medicaid Hospice and CAP/C; however, the CAP/C case manager and your agency will have to plan and coordinate services carefully to avoid duplication.

REMEMBER: *CAP/C cannot provide services that duplicate or replace the care that is the responsibility of the hospice agency.*

7. **Q.** May the CAP/C case manager select which agency provides CAP/C PCS to CAP clients?

A. No. According to Federal regulations, a CAP client has the freedom of choice to select among enrolled Medicaid providers. This applies to CAP services as well as other Medicaid services, such as durable medical equipment and home health services. The case manager may assist the client and family in selecting an agency, such as telling the client which agency serves a part of the county, and may answer the client's questions, but may not attempt to restrict the client's choice.

8. **Q.** Our agency has been requested by a case manager to provide CAP/C Personal Care. We are enrolled to provide CAP/DA In-Home Aide Services and also enrolled to provide regular Medicaid PCS. May we provide CAP/C Personal Care?

A. Not until you get DMA's approval of an amendment to your CAP provider agreement to include CAP/C Personal Care Services.

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